

**Supplemental Agreement to Pay Benefits**

(formerly: Supplemental Memorandum of Agreement)

Virginia Workers' Compensation Commission

1000 DMV Drive Richmond VA 23220

**SEE INSTRUCTIONS ON REVERSE SIDE****The boxes  
to the right  
are for the  
use of the  
insurer**

Reserved

VWC file number

Insurer code

Insurer location

Insurer claim number

<b>Employer</b>			
Name of employer (see Employer's First Report)		Address	
Phone number	Federal Tax Identification Number		
<b>Employee</b>			
Name of employee		Phone number	Cause of injury/ illness
Address		Date of birth	Nature of injury/ illness(incl. body parts)
		Social security number	City or county where injury/illness occurred:
Date of injury or illness	List first seven days of incapacity	Pre-injury Average Weekly Wage	
<b>Temporary Total</b>			
<p>\$ _____ shall be paid per week during total incapacity, beginning ____ / ____ / ____.</p>			
<b>Temporary Partial</b>			
<p>\$ _____ shall be paid per week during partial incapacity beginning ____ / ____ / ____, based on a current weekly wage of \$ _____, compared to a pre-injury average weekly wage of \$ _____.</p>			
<b>Permanent Partial</b>			
<p>\$ _____ shall be paid per week for a period of _____ weeks beginning ____ / ____ / ____, based on _____ % loss (or loss of use) of the _____, payable _____. (body part) (payment interval)</p>			
Employer	Print Name	Phone	Date
		( )	/ /
Signature of Employee, guardian, or committee	Print Name	Phone	Date
		( )	/ /
Insurer or authorized representative (signature of processor)	Print Name	Phone	Date
		( )	/ /
Name of Insurer	(This space reserved for Commission use)		
	Fee		
Name and address of employee's attorney (if represented)	<p>Approved by _____ Date _____</p>		

This report is required by the Virginia Workers' Compensation Act

Supplemental Agreement to Pay Benefits  
VWC Form No. 4A (rev. 9/1/99)

**FILING INSTRUCTIONS**  
(Instructions Updated 09/01/07)

**Supplemental Agreement to Pay Benefits**  
**VWC Form No. 4A**

1. This form is completed whenever additional periods of disability occur for an accident or illness for which an initial Agreement to Pay Benefits has already been submitted to the Commission. Submit the completed form to the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, VA 23220. Note: If additional consecutive periods of temporary partial disability occur, a Supplemental Agreement to Pay Varying Temporary Partial Benefits (VWC Form No. 4G) may be filed in place of this form
2. For subsequent periods of compensation benefits, a Supplemental Agreement to Pay Benefits (VWC Form No. 4A) or a Supplemental Agreement to Pay Varying Temporary Partial Benefits (VWC Form No. 4G) must be filed.
3. The information at the top right of the form should be provided by the insurer. Please note that the insurer code refers to the five-digit numeric code assigned by The National Counsel on Compensation Insurance (NCCI). Self-insured employers are assigned a similar five-digit code number by the Virginia Workers' Compensation Commission.
4. Incomplete or illegible forms will either be returned to the insurer for proper completion or they will be rejected.
5. When filling out this form, please be sure to provide a brief description of how the accident or illness occurred in the "Cause of Accident" box. Please indicate **all** parts of the body affected and which are accepted, in the "Nature of Injury" box.
6. Note that compensation is paid beginning with the eighth (8<sup>th</sup>) day of disability resulting from a work related accident or illness. If the disability period exceeds more than 21 days, then compensation is owed retroactively for the first seven (7) days of disability. The first seven (7) days of disability includes all days or parts of days when the injured employee was unable to earn a full day's wages, or was not paid a full day's wages, due to the injury. These dates should be the same as reflected on the Agreement to Pay Benefits (VWC Form No. AW4).
7. When an employee receives full wages during disability, these days are to be counted towards the waiting period and any subsequent days of disability. Agreement forms need to be completed in their entirety, giving dates and amounts the employee would have been entitled to receive in compensation benefits covering all periods of disability.
8. **Definition of Types of Benefits:**  
**Temporary Total (TT) Disability** – Injured employee is totally disabled for work, and is entitled to receive compensation for a period of total wage loss, based upon 66 2/3% (.66667) of the pre-injury average weekly wage.\*  
**Temporary Partial (TP) Disability** – Injured employee is partially disabled for work, but is entitled to receive compensation for a period of partial wage loss, based upon 66 2/3% (.66667) of the difference between the pre-injury average weekly wage and the post (or current) average weekly wage.\* Forms received without specific dollar amounts or those that reflect the word "Various" will be rejected.  
**Permanent Partial (PP) Disability** – Injured employee is entitled to receive compensation based upon the loss of use or the loss of a ratable body member, based upon 66 2/3% (.66667) of the pre-injury average weekly wage for a specified number of weeks, pursuant to Va. Code §65.2-503. Please attach a copy, to the agreement form, of the doctor's report or the amputation chart that supports the permanency rating.\*  
    \*Compensation rate is subject to yearly maximum and minimum allowances.  
    \*All wage information and compensation rate(s) reflected on the form(s) should be based on weekly figures.  
    \*The previously established average weekly wage should be used when completing this form.
9. The signatures of the employee and a representative of the employer or insurer (including the insurer's name and address) are required. If these signatures are missing, this form will be returned.
10. **Forms:** Additional copies of this form are available without cost by writing to the Commission. This form is also available on the Commission's Website, at [www.vwc.state.va.us](http://www.vwc.state.va.us). Please note that color coding of the forms greatly increases the Commission's efficiency in processing claims, and that any alternative versions of the form you develop yourself require prior approval by the Commission. Address your inquiries to "Forms" at the listed Virginia Workers' Compensation Commission address.
11. For questions or assistance with completing this form, please contact the Awards Unit using the Commission's toll-free number at (1-877) 664-2566.